CERTIFICATE OF VISION (Eye Referral)

State Form 22106 (R2 / 11-96)
Bureau of Motor Vehicles
Driver's License Division

The request for your Social Security number is VOLUNTARY, and you will not be penalized for not supplying it.

The information contained on this form is CONFIDENTIAL according to 140 IAC 4-3 and IC 9-14-4.

The attached certificate is presented by _____ SS No. _____ to permit an evaluation of a possibly disqualifying visual condition **identified** in the course of a routine driver's license examination. Our basic vision screening indicates need for further examination. Optec 1000 BMV findings are as follows:

ACUITY			GLASSES	VISUAL FIELDS - LEFT	VISUAL FIELDS - RIGHT
Both 20 / _____	Right 20 / _____	Left 20 / _____	☐ No ☐ Yes	☐ 70°T ☐ 55°T ☐ N	☐ N ☐ 55°T ☐ 70°T

Examiner's comments:

Date (*month, day, year*)	Branch number	By (*Driver's License Examiner*):

CERTIFICATE OF EXAMINATION BY EYE DOCTOR (OPHTHALMOLOGIST OR OPTOMETRIST)

Your findings recorded on this certificate will make possible a proper and authoritative evaluation of the applicants visual qualification for safe motor vehicle operation.

I, _____ , being licensed to practice _____ in the State of Indiana, have this date _____ examined (name) _____ (age) _____

(address) _____ (telephone) _____

for visual conditions which might have direct bearing upon his or her qualifications for a license to drive and I herewith submit my report.

WITHOUT LENSES			WEARING BEST POSSIBLE PRESCRIPTION		
Right Eye 20 / _____	Left Eye 20 / _____	Both Eyes 20 / _____	Right Eye 20 / _____	Left Eye 20 / _____	Both Eyes 20 / _____

Horizontal Diameter of Visual Fields		Fields attached	
Right	Left	☐	NOTE: See vision requirement chart below.

Diagnosis of visual condition(s):

Further vision loss is: ☐ Unlikely ☐ Possible ☐ Likely

Prescription needed to achieve best corrected visual acuity:

Applicant has above-stated prescription: ☐ Yes ☐ No

3	VISION REQUIREMENT CHART (***Check one if applicable***)
	I — One eye 20/40 or better, other eye 20/40 or better, unaided or corrected with glasses or contact lenses. * NO RESTRICTIONS
	II — Best eye 20/40 or better, other eye 20/50 to Blind, unaided or corrected with glasses or contact lenses. * OUTSIDE R/V MIRROR (B restriction)
	III — One eye 20/50, other eye 20/50, unaided or corrected with glasses or contact lenses.* GLASSES REQUIRED (A restriction)
	IV — Best eye 20/50, other eye 20/70 to Blind, unaided or corrected with glasses or contact lenses. * GLASSES REQUIRED *, OUTSIDE R/V MIRROR, DAYLIGHT DRIVING ONLY (A, B, C restrictions)
	V — One eye 20/70, other eye 20/70, unaided or corrected with glasses or contact lenses. * GLASSES REQUIRED *, OUTSIDE R/V MIRROR, DAYLIGHT DRIVING ONLY (PERSON MUST HAVE PROOF OF NORMAL PERIPHERAL VISUAL FIELDS) (A, B, C restrictions)

* License valid only while wearing glasses or contact lenses WHEN applicant requires the aid of glasses or contact lenses to pass Driver's License Vision Examination. Doctor must certify in writing if glasses will not improve vision.

Signature of doctor	Typed or printed name of doctor

M.D., O.D. address (*number and street, city, state, ZIP code*)	Telephone number

I authorize this information to be released to the Indiana Bureau of Motor Vehicles.	Signature of applicant	Date signed (*month, day, year*)

APPLICANT MUST RETURN COMPLETED CERTIFICATE FOR FURTHER EVALUATION.

DO NOT RETURN THIS FORM TO THE LICENSE BRANCH UNTIL YOU ARE USING YOUR NEW PRESCRIPTION FOR GLASSES OR LENSES.

Bureau of Motor Vehicles, Driver Licensing , Room IGCN-N405, 100 N. Senate Ave., Indianapolis, IN 46204, Telephone (317) 233-6000, ext. 2